2006 State Health Report

Washington State Board of Health

Discussion Draft

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[INSERT LETTER FROM GOVERNOR IN JULY]

[THORBURN ESSAY]

Health: A Top Priority for Washington State

By Kim Marie Thorburn, Chair, State Board of Health

Since 1990, the State Board of Health has been responsible for producing a biennial state health report "that outlines the health priorities of the ensuing biennium." RCW 43.20.50 stipulates that the report must be produced in even numbered years and that the Governor must approve, modify, or disapprove the report. The report is intend to be used by state agency administrators as a guide for preparing agency budgets for the upcoming biennium and for developing legislation to propose to the Legislature. The 2006 State Health Report is meant to be used to develop budget proposals for the 2007-09 biennium and legislation that the agencies would like the 2007 Legislature to consider.

Over the years, these reports have changed somewhat in length, format, and content. The types of input considered when drafting the report also have varied. The public has always been consulted. The Board is required to hold forums across the state every five years, and it has typically used polls, surveys and other tools to gather additional input. It is required, as well, to solicit ideas from the other agencies involved in health issues. The Board also consults with policy makers and experts in public health and medical care. In 2001, it began specifically to solicit suggestions from members of local boards of health, many of whom are elected local officials. And of course, the Board considers the best available scientific data and research findings.

In recent years, the Board has attempted to be increasingly strategic about what it includes in the report, focusing in each time on a limited number of strategic directions. In recent years, they have tended to be very similar—they have addressed, in one way or another, the capacity of the public health systems, the cost and quality of medical care, access to appropriate health services, healthy behaviors, and the environment. This year is no different, and in this essay I will lay out the Board's five strategic directions for health care in the state of Washington.

But there are several aspects of this report that are unique, and I wanted to mention them briefly. One difference is the timing of public input. When the Board held public forums in the past, it always scheduled them before working on the report. This year, we decided to try something new—preparing a discussion draft of the report first and then asking for comments on the draft at the public meetings.

Another difference is the degree of involvement of other agencies. As I mentioned above, the Board is required to consult with agencies that are involved with health, but in recent years it has gone beyond consultation. In 2000 and 2004, the Board collaborated with the Governor's Subcabinet on Health under the Locke administration, issuing the report under the signature of the chairs of both the Board and the Subcabinet. In this report, the Board has gone even farther still, inviting to heads of other agencies to describe health priorities in their own words.

The other thing that is different about this report is the active involvement the Governor and her staff members have had in defining health priorities for the executive branch of

state government. When Governor Christine Gregoire took office in 2005, she immediately declared her three health policy goals—contain costs and improve quality, cover all kids by 2010, and make Washington the healthiest state in the nation. She then convened interagency workgroups to develop specific policy initiatives in each of these areas. As those initiatives have developed, it has become increasingly clear that the Governor's health policy agenda corresponds nicely with the strategic directions proposed by the Board.

In this report, the executives of the three agencies that were asked to play a lead role in convening the interagency workgroups will describe each of the Governor's initiatives. But first, I would like to describe the Board's five strategic directions for the 2007-09 biennium.

Improve public health system capacity

Whether it's by preparing against the potential for a form of avian influenza virus that spreads readily among humans, keeping food and drinking water safe, teaching kids to avoid tobacco, or a myriad of other activities, public health is always working for a safer and healthier Washington. The people of this state expect and deserve a public health system that responds. Yet even with an infusion of federal resources to enhance public health emergency preparedness, public health system resources have eroded over the past decade.

The state's public health system is better prepared for an emergency since the East Coast anthrax outbreak in 2001. Agencies have strengthened partnerships with departments of emergency management, improved disease surveillance and risk communication capabilities, and practiced emergency plans. There remains room for improvement, but progress has been made.

At the same time, a rising rate of obesity puts more of our population at risk for a variety of chronic diseases. HIV and other sexually transmitted disease infections occur at an alarming rate. Injuries continue to be a major cause of death and long-term disability in the young and old. Too many women, especially those with challenges like chemical dependency and family violence, don't receive adequate prenatal care to ensure a healthy start for their infants. A stronger public health system could reverse these trends.

The progress that we have witnessed on diminishing tobacco use is a public health success story. Fewer young people are smoking and adult users are quitting. A well-resourced, multi-pronged program, including public awareness campaigns, cessation treatment, community- and school-based programs, and evaluation, is responsible for this health improvement. Tobacco prevention and control is an example of what the public health system can accomplish when capacity is adequate.

The Joint Legislative Select Committee on Public Health Financing created by SCR 4410 during the 2005 session is studying public health system capacity and will report its findings to the Legislature in 2007.

Governor Gregoire's Healthy Washington initiative (see page TK) depends on a robust public health system. Access to quality health services is important to caring for sick and injured people but dealing with the broad determinants of health—socioeconomic status,

the environment and behaviors—is needed to prevent disease and injury and promote health.

Great advances in the health of the population come through disease and injury prevention activities such as immunizations, sanitation, and vehicle occupant restraints. Impacting the broad health determinants is the work of the public health system.

Improve health by promoting healthy behaviors

Healthy behaviors contribute to healthy lives. Chronic diseases and injuries rank among the principle causes of injury, illness, and death (morbidity and mortality) today in Washington. Much of the morbidity and mortality could be prevented or postponed with good nutrition, adequate physical activity, attention to safety, avoidance of harmful substances, and safe sexual behaviors.

Individuals are responsible for their behaviors, but careful choices are reinforced by strong policy, a supportive environment, and good information. The reverse can be seen when these elements are lacking. Poor nutrition caused by reliance on fast and pre-prepared foods along with physical inactivity related to our dependence on automobile travel have contributed to an epidemic of obesity, which increases the risk of several chronic diseases and injuries.

Tobacco prevention and control is the success story. After years of increasing smoking rates encouraged by glamour messages from Big Tobacco, the trend is finally reversing. Smoking rates in Washington are among the lowest in the nation. A well-funded counterattack, consisting of counter-advertising, policy and resource support for smoking cessation, school- and community-based programs, and improved environmental tobacco smoke policy, has brought down smoking rates along with smoking-related diseases

Other advancements have been seen in injury prevention through the requirement of seat belts, child passenger restraints and helmets. Policy approaches to advancing healthy behaviors are often controversial. Gun control is a good example, as are science-based sex education and condom distribution. Well-formulated observational and research studies are important to providing a strong scientific basis for our policy choices.

Healthful behaviors begin early in life when they are encouraged by families, schools, and communities. Governor Gregoire's Healthy Washington initiative is exploring school-based programs that have worked to promote healthy behaviors in kids (see sidebar, page TK).

School districts that have traded fattening snacks in vending machines for healthier choices have shown that children will change their eating habits. New approaches to health and physical education are re-engaging youth to be more active. Support for these activities may lead to lifelong healthy nutrition and physical activity behaviors.

Assure environments that promote and protect human health

Environmental protection efforts conducted by the state Department of Ecology and other agencies do more than protect natural ecosystems, create recreational opportunities, promote tourism, and improve the quality of life—to the extent that polluted air, water and soil, as well as contaminated food, have an adverse impact on human health, these efforts can improve the health of the people of Washington.

Toxic air pollutants can lead to birth defects cancer and other forms of illness. Millions of pounds of toxic pollutants enter Washington's air each year, primarily from diesel exhaust fumes, gasoline vapors, and wood smoke. The Puget Sound Clean Air Agency has estimated that 700 cancer cases a year in Washington are attributable to airborne toxins. Small airborne particles, particularly those less than 2.5 microns across, contribute to asthma, sudden infant death syndrome, heart disease, lung disease, and cancer. The Harvard Six Cities study followed 8,000 people for 177 years and found a 26 percent increase in death rates for people living in areas with elevated levels of particulates.

Contaminants are also found in our water. Some, like mercury, persist in the environment for many years and accumulated in the food supply. They are associated with nervous system disorders, reproductive problems, learning difficulties and developmental damage.

Our physical environment can also influence our behaviors in ways that affect our health. If we don't have ready and affordable access to trails, parks and other recreational facilities, for example, we are less apt to be physically active—and inactivity contributes to our epidemic of obesity.

As Mary Selecky discusses in her essay on Page TK, the Governor's Healthy Washington group is working with stakeholders to address environmental contaminants in places where children congregate. For a variety of reasons, children suffer more from exposure to environmental toxins than adults. The group is also supporting the Department of Ecology's efforts, in collaboration with the Department of Health, to reduce to number of "persistent bioaccumulative toxins," such as mercury, that enter our environment. On page TK, Ecology Director Jay Manning explains what is meant by persistent bioaccumulative toxins and discusses the state's approach to decreasing the harm they do to the environment and human health.

In addition, the Board and its partners will be working to encourage better communication between urban planners and architects and local health officials to assure that the physical environments we build support healthy lifestyles.

Reduce health disparities

Health disparities are measurable differences in health outcomes experienced by different populations. Unequal distribution of social, economic and political resources and structure among populations creates inequities and disadvantages for some groups. The inequities result in poor access to societal benefits, increased exposure to risks, and innate predisposing conditions, which underlie health disparities.

Population differences among which we see health disparities include gender, age, race or ethnicity, education, income, language, disability, geographic location, and sexual orientation. Reducing health disparities would require more than improving access to health care since disparities arise from social, economic and political inequities. Broad health determinants, such as educational attainment, employment, income, lifestyle behaviors, discrimination, and environment, can all contribute to health disparities. These factors must be identified and addressed

Katrina and other natural disasters during 2005 were reminders of the impact of health disparities. People in poverty and people of color suffered disproportionately. Contributing to their suffering were issues such as inability to evacuate due to lack of transportation, substandard housing, a greater burden of chronic diseases and disability, or risk of exposure to violence. Health disparities equate to earlier death, greater disease and injury burden, decreased quality of life, loss of economic opportunity, and a sense of injustice for affected populations. Society also suffers from less productivity, higher health-care costs, and social inequity.

Health disparities can be recognized by such examples as higher tobacco smoking rates and poorer nutrition among less educated Washingtonians, or more use of chewing tobacco among rural men. Higher rates of vaccine-preventable diseases and HIV infection occur among certain racial groups. Birth outcomes also vary by race.

It is the role of the public health system to serve as a convener to carry out the work of reducing health disparities. Impacted populations must be at the table to guide culturally sensitive approaches. Partnerships and coalitions are needed to tackle the broad determinants related to specific health issues. In her sidebar on page TK, Ellen Abellera, Executive Director of the Commission of Asian and Pacific American Affairs, explains how state government has begun the process of involving communities and stimulating partnerships to address disparities. A commitment to greater social, economic, and political equity as the foundation to reducing health disparities is in the interest of all Washingtonians.

Assure access to health services

Polling indicates that Washingtonians' greatest health concern is whether or not they can access needed health services. Personal angst and policy debates center on health care costs, from lack of insurance to rising out-of-pocket costs to unaffordable premiums. The access problem is further compounded by health labor shortages. Nursing positions go unfilled in hospitals. Emergency services close due to lack of certain physician specialty coverage. People is rural communities must travel long distances for dental care.

Solving the access crisis is like the blind men and the elephant. There are many stakeholders with many perspectives. Payers and purchasers want costs controlled. The usual means to do this is to limit benefits or eligibility, yet patients want any service they perceive is needed. Providers look for sufficient reimbursement with no restrictions on practice. All of these interests detract from the fundamental discussion about what health services should be available and to whom.

Unlike education, health care was not historically recognized as a universal franchise in our state, but there is unspoken sentiment that we should all be able to get it. Washington has taken significant but incremental approaches to ensuring access. For example, it has established a state health insurance program. Now there is interest in guaranteeing that what we pay for is beneficial; that is, evidence-based.

From 1999 to 2003, the Washington State Board of Health underwent a process, including review of evidence and public input, to identify a core set of health services that should be available to ensure a healthy state. Called the menu of critical health services, the list provides a basis for the discussion about what health services should be universally accessible. As we continue measured steps toward improving health care access for Washingtonians, the menu of critical health services could be used to determine what everyone should receive while we struggle with how to pay and other barriers to access.

Improving access to health services will require state and federal policy changes. In the meantime, local communities have mobilized to identify and fill gaps. Public health agencies work with partners to ensure the availability of services and outreach to vulnerable populations.

Health care for all kids is a worthwhile investment for Washington. Robin Arnold-Williams, Secretary of the Department of Social and Health Services, explains on page TK why this is a priority for Governor Gregoire's administration. Ensuring that our youth receive immunizations, preventive screening, oral health care and other routine pediatric services ensures a healthy start to a lifetime. While not all disease and injury can be prevented, access to good preventive health care for our children is our best opportunity to minimize risks.

Healthy kids have better access to the social and economic benefits of our society. They receive maximum advantage from the educational system and are most likely to grow to be productive adults. Access to health care is the cornerstone to a healthy beginning.

Washington is devoting resources to pay for health care for all of our youth. Public programs are available for those who cannot access private insurance. A sustained commitment and outreach should successfully cover all kids.

Increase quality and contain costs

America spent 16 percent of its gross national product on health care in 2004, according to the federal government. Health care, not housing, is the biggest purchase most of us will make in our lifetime. As a nation, we spent $1.9 trillion a year on health care in 2004, or $6,280 a person. That's a 7.9 percent increase over the previous year's total. But are we buying the right things, are receiving what we pay for, and are we getting top quality? According to the World Health Organization, the United States ranks first among nearly 200 member nations in per capita health care expenditures, but it ranks 29th in years of healthy life expectancy.

It is not always best to buy the cheapest product. We commonly consider quality when purchasing a car, yet rarely factor quality into medical purchasing. The Institute of

Medicine Report *To Err Is Human: Building a Safer Health System* found that medical mistakes cause 44,000 to 98,000 deaths each year—more than HIV/AIDS, breast cancer, or vehicle accidents. These medical mistakes are largely attributable to poorly integrated services, poor information services, and other types of system errors. The report estimated the annual costs of preventable errors at $17 billion to $27 billion.

Government is the primary funder of health care in the United States, according to the Employee Benefit Research Institute and other sources. A major share of government health expenditures comes from state funds and federal funds administered by states. It is not surprising, therefore, that health care is considered the most critical cost driver for state government.

As Steve Hill, Health Care Authority Administrator, points out in his essay beginning on page TK, health care is projected to consume almost 28 percent of state spending in 2006, compared to 22 percent in 2000. If one includes federal funds appropriated by the state for programs such as Medical Assistance, the percent of all appropriations that go to provide health insurance, direct care, and public health programs starts to approach 50 percent.

Steve Hill rightly notes that this trend is unsustainable, and that every new dollar spent on health care means less money available for other government services. Moreover, as health care costs rise, the state will have less money to expand access by covering more of the uninsured and underinsured, particular children. Worse, it will feel pressured to cut back on current enrollment levels or reduce benefits in programs like the Basic Health Plan and Medicaid. That would mean *less* access to appropriate care.

As a major purchaser of health care services, Washington State is committed to obtaining value—value can be defined as quality divided by price. Cost containment is only one piece of the health care purchasing puzzle. The state can improve value by improving efficiency in contracting and purchasing and by improving patient safety and overall quality of care. On page TK, Gary Weeks, Director of the Department of Labor and Industries, discusses on example of a state-sponsored effort to control costs and improve quality simultaneously.

[ABELERRA SIDEBAR TO THORBURN ESSAY]

Working to eliminate health disparities

By Ellen M. Abellera, Executive Director, Commission on Asian Pacific American Affairs

Washington State can become the "healthiest state in the nation" only by eliminating the "health gap" that lowers the quality of life, limits economic advancement, and shortens life expectancies for many subgroups of our population, including people of color.

Washington State held the first Diversity Health Summit to eliminate health disparities for people of color on September 30, 2005. Conference sessions covered a broad range of topics that connected with Governor Gregoire's health priorities—recognizing the importance of healthy children, exploring prevention and wellness, and looking at ways to better identify and screen for health conditions for minority and ethnic populations of all ages.

In Washington State and nationally, Asians and Pacific Islanders, Blacks, Hispanics and Native Americans suffer more than whites from cancer, diabetes, hepatitis, heart disease, stroke, HIV/AIDS, tuberculosis, and other ailments. Most of these groups live much shorter lives than whites.

The summit was a call to action collaboratively convened by the state's four ethnic commissions: the Commission on African American Affairs, the Commission on Asian Pacific American Affairs, the Commission on Hispanic American Affairs, and the Governor's Office of Indian Affairs. Other partners included the Governor's Office, Department of Health, State Board of Health, Washington Health Foundation, Department of Social and Health Services, Susan G. Komen Breast Cancer Foundation and HumanLinks Foundation.

The fruits of the summit were intercultural networks that will continue to work in four areas: providing more health outreach and prevention in communities of color; improving health care access, insurance, and availability in communities of color; addressing behavioral and mental disparities among communities of color; and promoting greater cultural competence in the health care community.

One of Christine Gregoire's first successes as Governor was extending health insurance coverage to 73,000 additional children—a move that promise to reduce disparities by improving access to care for low-income families, many of whom are people of color. We in state government must continue to imagine ways that we can do things differently to effect change for communities of color.

[MARY SELECKY ESSAY]

Better Health through Prevention and Partnerships

By Mary Selecky, Secretary, Department of Health

Governor Gregoire has challenged our state to be healthier. Success means that individuals will have a better quality of life while we lessen the trend of health care expenditures. It also means we must look at the roots of health to understand how we can improve it. To that end, the Governor has directed the Department of Health to convene a workgroup of key agencies to craft a prevention agenda for the state of Washington. The Healthy Washington Workgroup is framing a prevention initiative that involves collaboration between many partners: Department of Social and Health Services, Health Care Authority, Office of Superintendent of Public Instruction, State Board of Health, Department of Ecology, Department of Transportation, Community Trade and Economic Development, and Department of Agriculture. The workgroup's agenda embraces prevention in ways that are both timely and bold. Every one of us can be a part of the prevention story.

The Healthy Washington Workgroup is taking a long-range view. The group has set challenging goals that involve changing systems and behaviors. They begin with birth, with the intention that babies in this state are born into families able to support children in all the ways essential to lifelong health. Both ongoing and new work will address that goal. The workgroup will also investigate prevention from the perspective of lifestyle, picking up where science suggests it is possible to reduce the incidence of chronic disease. The group is focusing on reducing exposure to environmental toxins, especially for children who are so susceptible to their damaging biological impacts. And for those of us who have conditions, the prevention workgroup seeks ways to provide health care systems that help us stay as healthy as possible.

The Prevention agenda focuses on five goals:

1. Increase the proportion of children and youth who have a medical home.
2. Increase healthy eating and active life opportunities, including employer-focused initiatives.
3. Reduce the use of tobacco, alcohol and other drugs.
4. Create a coordinated approach to school health so that students have their health care needs met and are ready to learn.
5. Reduce exposure to harmful environmental toxins.

Increase the proportion of children and youth who have a medical home

A medical home isn't a place; it's an approach to providing high quality, comprehensive health care services. It's accomplished through a team of health care professionals,

including a primary care provider. A medical home coordinates all services that affect a child's health. Ideally it's in the community where the child lives and receives all educational, psychosocial, and health care support.

The focus of Healthy Washington is to increase the proportion of children and youth who have a primary source for health care. A medical home is a system of care that integrates prevention into all aspects of health care delivery. It includes early childhood health screenings, well child exams and care coordination. Health insurance is one of the keys to success. Covering all kids is one of the goals of the Gregoire administration.

Adults can benefit from a medical home as well. It's clear that managing chronic disease using the medical home approach results in much better health.

Increase healthy eating and active life opportunities—including employer focused initiatives

If the options for living a healthy lifestyle are easy, it is more likely that we will incorporate healthy activity into our lives. Research has shown that behavior choices and subsequent health outcomes are profoundly influenced by the culture surrounding us. Simply put, if people have access to healthy foods they are more likely to eat them. If neighborhoods have sidewalks or accessible walking trails people are more likely to exercise. The environment we live in directly affects our health. Living with chronic disease does not have to be an inevitable part of growing older. Through our own habits and behavior we can impact the onset and progression of serious health problems such as diabetes or heart disease.

Healthy Washington is addressing the leading causes of preventable illness by promoting both physical activity and nutrition policies that reach into communities where we work, live, play and go to school. Eating healthy food and increasing our physical activity every day is achievable for most of us in this state. The Healthy Washington workgroup is focusing on schools and employer-based initiatives. In 2004 the state passed legislation requiring Washington school districts to develop model school nutrition and physical activity policies for all students. The goal of this work is to have every school adopt policies that allow only foods and beverages that are consistent with national nutrition standards. The law also requires schools to adopt curricula and polices that provide quality physical activity for all students. While many schools across the state are achieving these goals, full implementation of the nutrition and physical activity standards is far from universal. Healthy Washington is working to have healthy choices for nutrition and physical activity available on every school campus in this state.

Employers play a central role in this important work to get our state healthier. All employers shoulder the growing cost of health insurance. Healthy Washington will recommend adoption of employer-based policies which create benefits and programs that improve employee health. These may include employee health assessments used to match health care services to known risks. Or it may involve the intervention of "personal coaches" who help employees navigate the health care system. Employers might also offer staff prevention benefits, like tobacco cessation or health club memberships. Other ideas involve the work place itself, supporting policies like "walking meetings" and

healthy vending foods. Healthy Washington will analyze and promote promising and effective employer-based initiatives aimed at keeping employees healthy. In addition, the Department of Health and the Health Care Authority are jointly working on a Governor's initiative for state employee wellness and health promotion. As Washington's largest employer, state government is striving to set an example by encouraging policies and behaviors that promote good health.

Reduce use of tobacco, alcohol and other illicit drugs.

Our state's commitment to tobacco prevention and cessation is saving lives and money. Washington is making great strides toward reducing tobacco use and preventing kids from starting this deadly habit. This work is a top priority for Healthy Washington. Since the state's Tobacco Prevention and Control Program began five years ago, 65,000 fewer youth smoke. Overall smoking is down 13 percent and Washington has 130,000 fewer smokers. The number of pregnant women who smoke has dropped 25 percent. While this work has made a big impact, there is a lot more to do in the years ahead. Almost 8,000 people a year die in our state because of tobacco use. Forty-five kids in Washington still start smoking every day. More than 10 percent of babies are born to mothers who smoke during pregnancy. Tobacco prevention and control has a direct impact on the health of people in Washington. Healthy Washington will continue to place a strong emphasis on this work.

Each year, prenatal alcohol use results in as many as 1,000 babies born in Washington with birth defects and developmental disabilities. Over their lifetime, a person born with fetal alcohol syndrome disorder costs our social service system about $2 million. It is a devastating condition that is entirely preventable because it simply doesn't occur when pregnant women don't drink alcohol.

Reducing fetal alcohol syndrome is one of Healthy Washington's prevention priorities. Key strategies include increasing chemical dependency treatment and support services for pregnant and parenting women and expanding access to all free fetal alcohol syndrome resources.

Create a coordinated approach to school health so that students are healthy and ready to learn.

Kids must be healthy to learn. When students are sick, distracted, or constantly absent, schools can't do their job. Learning can take a back seat to other more pressing concerns kids face. If schools do not deal with children's' health by design, they deal with it by default. The Healthy Washington Workgroup wants to increase the state's capacity to manage the important physical and emotional health needs of students.

Research has shown essential components to school health include quality health and physical education, counseling and support services, good nutrition practices, available health services, involved families, and school staff who model healthy practices. Many of these components not only affect student learning, they impact lifelong health. When students are taught about unintentional injury, violence, suicide, tobacco use, addiction,

unintended pregnancy, and nutrition, they learn they can prevent serious health problems. When they eat nutritious food at school, and get daily exercise, they are practicing healthy behavior. (See sidebar, Page TK, by Valoria Loveland, Director, Department of Agriculture.)

When the coordination works and all elements are present, schools see signs of reduced misbehavior, improved academic performance, fewer kids smoking, and reduced obesity. Under a federal grant, the Office of Superintendent of Public Instruction has funded a cooperative agreement with the Department of Health to encourage partnership and collaboration between health and education in the state. (See sidebar, Page TK, by Superintendent of Public Instruction Terry Bergeson.)

Reduce exposure to harmful environmental toxins

For a variety of reasons, children suffer more from exposure to environmental toxins than adults. They eat more food, drink more water and breathe more air per body weight than do adults. The younger kids are, the more susceptible they are. The developing nervous system is highly sensitive in the womb, and continues to be highly vulnerable right through the teen years. For these reasons, Healthy Washington is targeting children in efforts to reduce human exposure to environmental toxins. The key efforts of this initiative will address the impacts of contaminants on the health of children, particularly in school and daycare settings.

Mounting evidence continues to reveal the impact of toxins in the environment on childhood development. From the well known effects of lead to the more recent concerns over mercury and PCBs in fish, it has become clear that children are not “little adults” and can suffer deficits in learning and behavior from low level exposures in early life.

Healthy Washington is working with a variety of stakeholders to address environmental contaminants in places where children congregate. In addition, the group will continue to work with the Department of Ecology on strategies to reduce exposures to Persistence, Bioaccumulative Toxins (PCBs). These efforts will include continued evaluation of health risks from other emerging contaminants and increased efforts to effectively communicate health risk information to residents of Washington. (See sidebar, Page TK, by Department of Ecology Director Jay Manning.)

While people often equate health with individual behaviors, there are many factors that determine the health of people in our communities. The environment we live in, access to information and resources, and quality health care are all important elements as we work for a Healthy Washington.

[BERGESON SIDEBAR TO SELECKY ESSAY]

A new framework for addressing student health

By Terry Bergeson, Superintendent of Public Instruction

Too many of our children face economic, social and health barriers to learning. Drop out and testing data tell us that struggling students are disproportionately ethnic minorities or low-income students. These are the same children that our public health partners tell us are disproportionately impacted by health issues and chronic disease. Health and education are partners. Our collaborative efforts will ultimately strengthen Washington's students' health and contribution to our communities.

Although education's mandate is to provide students with academic skills and knowledge, I recognize the importance of meeting the diverse needs of students. Creating and maintaining a supportive learning environment is a pivotal aspect of successful school improvement efforts. Few students achieve their academic potential if they aren't healthy, safe, and supported at school.

Through federal and state resources, the Office of Superintendent of Public Instruction currently provides some funding and technical assistance for school health services in programs that reach families, services for homeless students, school food programs, safe and supportive learning environments, and many other critical activities that begin to break down some of the social and health barriers to learning. All schools and districts also have programs and staff to implement health and fitness education and maintain safe and clean facilities. Still, there are unmet needs that threaten student health and safety.

Coordinated school health provides the framework to address health within our education system and assist us in preventing kids from falling through the cracks. This framework is a way to talk about the health-related services and activities that promote learning across agencies and systems.

Until recently, few schools or districts have succeeded in fully implementing coordinated school health or quantifying the impact of this coordination on student health and achievement. In Washington State, partnerships between governmental and nongovernmental agencies have resulted in the implementation of the Healthy Schools Leadership Program (HSLP). This program assists schools in implementing the full coordinated school health model. Currently, through a coordinated school health grant funded by the Centers for Disease Control, the Office of Superintendent of Public Instruction and the Department of Health are partnering to offer a second cohort of HSLP.

Coordinated school health is an organizing principle for all of these activities and serves to ensure that there is less duplication of effort. We appreciate our partnership with SBOH to develop a system that operates smoothly and seamlessly for all children.

[LOVELAND SIDEBAR TO SELECKY ESSAY]

Students benefit from locally grown foods

By Valoria Loveland, Director, Department of Agriculture

With more than 36,000 farms operating in Washington and some 300 commercial crops available, students have incredible choices for locally grown foods when it's time to eat. And through our Farm-to-Cafeteria program, kids get that direct connection to local produce.

Farm-to-Cafeteria is a great idea that's paying dividends. Students learn about and enjoy healthy, fresh foods. Our farmers find a new market for their top-quality products. My department's Small Farm & Direct Marketing Program helps create these programs; it connected Washington farmers to 35 public and private school districts last year. (It also helps bring locally grown foods to nursing homes, hospitals, day care centers and others.)

Farm-to-Cafeteria programs take many approaches. Food services can showcase fresh apples, feature salad greens in a daily salad bar or highlight Washington-grown food at a one-time harvest meal or special event.

The consumer is a real winner. Because everything is local, foods are served at their peak of ripeness. Different foods come to market every season of the year, so there is always some new taste at the table. Customers give food service directors great reviews on variety and quality. And with the focus on fruits and vegetables, the program is also a boon for public health. When school kids eat more healthy foods, they are less likely to develop chronic weight problems, which can have lifelong health consequences.

One example of imagination and innovation happened at Lincoln Elementary School in Olympia. A parent proposed the idea of an Organic Choices Program for school lunches, featuring a salad bar with fruits, vegetables, whole grain breads and protein such as eggs, beans and cottage cheese. The idea really took off. Students and staff love the focus on healthy and delicious fruits and vegetables, and consumption of those foods increased by 27 percent. The program has expanded to 11 elementary schools in the Olympia School District, and other districts have taken notice. The U.S. Department of Agriculture singled out the program as a wonderful example of creativity in school food service. And with local farms providing many of these foods, our state's producers are reaping the benefits, too.

Farm-to-Cafeteria is also a great way to integrate health education and agriculture with the dining experience in the cafeteria. Schools can highlight locally grown foods during mealtimes, kickoff special events with local farm organizations, create nutrition curricula around school gardens, and take field trips to local farms.

Twenty-five schools across the state participate in our Free Fruit and Vegetable program to provide healthy morning or afternoon snacks at no cost to schools or students. And last year, 10 participating schools partnered directly with local farms to provide those foods. Local choices include sliced apples, small apples and pears, dried apple slices, cucumbers, fresh asparagus and mixed green salads. Not only do kids eat more fruit and veggies, they also learn about where food comes from. What a concept!

By building connections between farmers and food service buyers, Farm-to-Cafeteria and related programs increase the economic viability of small farms and strengthen Washington's agricultural economy. In these times of continued economic stress on our state's family farms, we will continue to develop relationships that boost the demand for high-quality local products. We're hopeful that by introducing chefs, retailers, food service directors and consumers to local farm products, we will create a demand that will last a lifetime.

Schools across the state are seeing the benefits of serving fresh local produce. These programs are a great way to enhance agriculture and nutrition, but they are not always easy to get started and keep going. More policy work is needed to maintain the connections already made between schools and farmers, and to assist more schools to develop these relationships. For example, as public entities, schools must be held accountable for how they manage taxpayer dollars. Appropriate financial safeguards are important, but we must make it easier for schools to develop purchasing relationships with farmers.

This spring, a group of state legislators from across the country will be coming to evaluate farm-to-school programs in Washington, and discuss policy issues that can assist with these programs. I look forward to their visit and hope that others in Washington take advantage of this idea.

More schools are buying into the Farm-to-Cafeteria connection all the time. We have developed a great resource, a 90-page Farm-to-Cafeteria Connections handbook that shows how to start a program, including numerous resources and case studies of successful projects. To get this free handbook, contact Kelli Sanger at (360) 902-2057, or e-mail her at ksanger@agr.wa.gov. The handbook is also on the WSDA Web site at http://agr.wa.gov/Marketing/SmallFarm/default.htm.

Every school should be interested in participating in a program that improves the quality of the food service, benefits the health of the kids, enhances the curriculum and gives a boost to local farmers.

[MANNING SIDEBAR TO SELECKY ESSAY]

Reducing toxins in our air, water and soil

By Jay Manning, Director, Department of Ecology

In 2000, the Department of Ecology (Ecology) released its Proposed Strategy to Continually Reduce Persistent, Bioaccumulative Toxins (PBTs) in Washington State.

PBTs are a distinct group of chemicals that threaten the health of people and the environment. They raise special challenges for our society and the environment because:

- PBTs are stable chemicals that remain in the environment for a long time without breaking down (persistent).
- Animals and people accumulate PBTs in their bodies, primarily from the food they eat. As these chemicals move up the food chain, they increase in concentration and linger for generations in people and the environment (bioaccumulative).
- Exposure to PBTs has been linked to a wide range of toxic effects in fish, wildlife and humans, including effects on the nervous system, reproductive and developmental problems, immune-response suppression, cancer, and endocrine disruption (toxic).

PBTs can travel long distances in the environment and generally move easily between air, water and land.

The *PBT Strategy* will guide the continual reduction of risks that PBTs pose to Washington's environment and people. Chemical action plans (CAPs), which are being developed by Ecology in collaboration with the Department of Health (DOH) and others for specific high-priority chemicals, are the primary means for developing and implementing specific reduction actions and activities.

Ecology recently adopted a rule to guide development of CAPs (Chapter 173-333 WAC). It is the first rule of its kind in the country; we hope that it will serve as a model for other states to follow.

Mercury was the first chemical addressed under the PBT Strategy. The Mercury CAP describes a process for virtually eliminating the use and release of mercury contamination resulting from human activities in Washington state. It was completed in February 2003 and was co-developed with the Department of Health (DOH).

In January 2004, then-Gov. Gary Locke asked Ecology and DOH to evaluate flame retardants, also known as PBDEs (polybrominated diphenyl ethers), and recommend ways the state could reduce potential threats from these chemical additives, which are used in everyday household products.

The PBDE CAP, finalized in January 2006, recommends that the Washington State Legislature ban all three of the commonly used forms of PBDEs (Penta-, Octa- and Deca-BDE). While the fire-safety benefits of using flame retardants are clear, a growing body of research indicates that PBDEs are building up in people's bodies, in animals and in the

environment. PBDEs have been measured in blood, fat, and breast milk in people around the world. The exact way people are exposed to PBDEs is not fully known, but recent research points to human exposure from air, dust and certain foods.

The three main types of PBDEs used in consumer products (Penta-BDE, Octa-BDE and Deca-BDE), have different uses and different toxicity. In 2001, the total PBDE volume worldwide was estimated at more than 67,000 metric tons, including 56,100 metric tons of Deca-BDE. Manufacturers of Penta- and Octa-BDE in the U.S. agreed to stop producing these two forms at the end of 2004. With the discontinuation of Penta- and Octa-BDE, Deca-BDE will account for 100 percent of PBDE use. Studies indicate that Deca-BDE can break down in the environment to the more toxic and bioaccumulative Penta- and Octa-BDE forms.

While additional research is needed to find a safer, effective and affordable alternative to Deca-BDE, the recommendations in the PBDE CAP were developed after a thorough consideration of what is known and what is not known. For more information, please see the PBDE Chemical Action Plan at http://www.ecy.wa.gov/biblio/0507048.html.

At the departments of Ecology and Health, we believe it is important that we tackle PBTs in partnership with others, including our fellow state agencies and lawmakers, along with other states, the federal government and even other nations. Both the Mercury and PBDE CAPs were developed through a multi-program, multi-agency effort, with external stakeholders involved at each step.

So what's next? Two of Ecology's goals as Washington's principal environmental management agency are to prevent pollution and clean up existing pollution. Along those lines, one of my three strategic priorities for Ecology is to reduce toxic threats.

In recent years, we have found an increasing trend of toxic substances found in the sediments of Puget Sound, in the fish we eat, and in our homes, offices and bodies. Our toxics strategy has four key components:

- Improve our understanding of toxic chemicals in sources and products that are a threat, and determine how best to phase them out.
- Get toxics out of the air we breathe.
- Get toxics out of our water and soil.
- Work with businesses to reduce the use and production of hazardous substances.

The PBT efforts are an important part of this priority. We are currently developing, in consultation with DOH, our multi-year schedule to prioritize chemicals for the preparation of chemical action plans. Development of this schedule will follow a process outlined in the PBT rule. The process will include getting input from other agencies, as well as the general public. For the 2007-2009 biennium, we intend to produce two more action plans, but I don't yet know which two will be chosen. We will know once the multi-year schedule is finalized. We do know, however, that we will need additional funding, first to develop the CAPs, and then to implement them. We may also need some additional authority, but I believe that would be rolled in to some subsequent agency legislation.

We are only focusing on chemicals on which we can truly make a difference. For example, as a result of the Mercury Chemical Action Plan, it became illegal to sell or distribute thermometers, manometers (pressure-measuring instruments, such as blood-pressure gauges) and novelty items such as toys, games, or jewelry that contain mercury as of Jan. 1, 2006.

Our PBT rule will guide us in prioritizing future work. And with the continued efforts on the part of Ecology, DOH and other state agencies, as well as external interested parties, we can significantly reduce the risks to the health of our citizens and the environment from exposure to PBTs.

[ARNOLD-WILLIAMS ESSAY]

Covering All Kids by 2010

By Robin Arnold-Williams, Secretary, Department of Health and Human Services

[NOTE: THIS A PLACEHOLDER AND HAS NOT BEEN APPROVED BY SECRETARY ARNOLD-WILLIAMS]

Governor Gregoire's health care agenda has three major health goals to improve the health of Washington residents and to make our state a national leader in health care. These include:

- Improving the quality and efficiency of health care in Washington;
- Making Washington the healthiest state in the nation
- Covering all children in Washington with health insurance by 2010.

The overriding theme of this agenda is our state's commitment to the health of Washington's children.

Health insurance for children

The Governor believes that children's coverage is essential to the future of our state. When children have access to cost-effective preventive and health care treatment it is not only an important step toward good health but guarantees they have the capacity to use their education to become productive adults in the 21st century. Having access to health coverage means healthier kids; healthier kids mean healthier, more productive adults.

National studies have found:

- "Uninsured children have less access to health care, are less likely to have a regular source of primary care, and use medical and dental care less often compared to children who have insurance. Children with gaps in health insurance coverage have more access problems than children with continuous coverage."
- "Previously uninsured children experience significant increases in both access to and more appropriate use of health care services following their enrollment in public health insurance programs."
- "Uninsured children often receive care late in the development of a health problem or may not receive any care. As a result, they are at higher risk for hospitalization for aggravated conditions, late-stage diagnoses, or missed diagnoses of serious and even life-threatening conditions."
- "Undiagnosed and untreated conditions that are amenable to control, cure, or prevention can affect children's functioning and opportunities over the course of their lives. Such conditions include iron deficiency anemia, otitis media, asthma, and attention deficit-hyperactivity disorder."

There also is national recognition that coverage for children, like coverage for our seniors through Medicare, should be a national priority. To this end, Congress enacted that State Children's Health Insurance Program (SCHIP), which is a federal/state partnership to make available publicly financed health coverage for all low-income children.

Washington: Leader in health coverage for children

Washington has long been a national leader in providing health insurance for its children. In 1988, our state implemented the First Steps Program, which provided health coverage and prenatal care to pregnant women and infants in households up to 185% of the federal poverty level ($30,700 per-year for a family of three). This program has lead to a major reduction in infant mortality and low-birth weight children in our state. Washington ranks third lowest state in the nation for infant deaths per 1,000 livebirths (deaths to infants from birth to 364 days of age) and low birth weight births per 100 livebirths (less than 2,500 grams or 5 lbs. 8 oz.) and is the second lowest state in the nation for very low birth weight births per 100 livebirths (less than 1,500 grams or 3 lbs. 4 oz.).

In 1991, Washington made available Medicaid coverage to children in families up to 100% of poverty ($16,600 per-year for a family of three). Coverage was also made available to children who were not eligible for Medicaid due to their citizenship status. In 1994, our state expanded Medicaid coverage for children up to 200% of poverty ($33,200 per-year for a family of three). As part of our state's health reform efforts, these children receive coverage through our Healthy Options (HO) managed care program, which is designed to provide a medical home to ensure primary and preventive care.

At the time Congress enacted the SCHIP program in 1997, Washington was one of only four states that were already covering children at the national 200% poverty level target. In 2000, we implemented our SCHIP to offer health coverage for children in families up to 250 percent of poverty ($41,500 per-year for a family of three). Washington's SCHIP is the 6th highest in coverage level among states.

To ensure that children have access to seamless and appropriate coverage, Washington's publicly financed children's programs offer the same coverage, which is based on the Medicaid program. Families in the Basic Health Program (BHP) are able to access full-scope coverage for their children without cost-sharing through the BHP+. Today, some 27,000 children are enrolled in BHP+.

These efforts have yielded gains in increasing health coverage for children. In 1998, the Washington State Population Survey reported that the uninsured rate for children was 7.8 percent. In 2000, the uninsured rate dropped to 5.5 percent and in 2002 the rate was 4.5 percent.

Due to data limitations, national comparisons are difficult to make. The Census Bureau's Current Population Survey (CPS) show that in 2003-04 Washington ranked 13th in health insurance coverage for all children and eighth in coverage for low-income children (i.e., children in households below 200% federal poverty). Vermont has the lowest uninsured

rate for children and Texas had the highest rate. Washington is roughly among the top quartile of states in terms of providing coverage to children.

Governor gregoire's coverage initiatives for children

During the state's budget crisis, we were faced with downturns in Washington's economy and a continued increase in health expenditure growth rates (9 percent per year) that were three times greater than state revenue (3 percent per year). Medical assistance reductions in that era included a rollback in BHP coverage from 130,000 to 100,000 slots, reductions in the Medicaid adult dental program, elimination of 12-month continuous eligibility for Medicaid children, and a Medicaid waiver to adopt premiums for Medicaid children in households above 150 percent of the federal poverty level.

We also terminated our Children's Health Program (CHP) for non-citizen children, but attempted to transition this population into the BHP. Initially, some 13,000 children and adults enrolled in BHP by November 2002. Unfortunately, that enrollment dropped to 3,500 by June 2005. In total, the various changes in Medicaid policies that were implemented in April and July 2003 resulted in an increase of some 39,000 uninsured children by October 2004.

Upon taking office a few months later, the Governor initiated a series of policy changes to reverse those trends. She directed the Department of Social and Health Services (DSHS) to reinstate 12-month continuous eligibility for the Medicaid children's program. She also opposed implementation of premiums for children in households below 200% of the federal poverty level. (Premiums for SCHIP children – i.e., families between 201% and 250% of FPL -- were continued at $15 per month.) These policy changes will provide coverage for an estimated 70,000 additional children during the 2005-07 biennium. The Governor's budget included over $140 million in new funding to provide this coverage.

In examining children's uninsured rates, 70% of uninsured children were in households below the 250% level covered by publicly funded health programs for children. Except for non-citizen children, our state is making affordable health coverage available for the vast majority of low-income children. To address the gap for in coverage for non-citizen children, the Governor requested legislation to reinstate CHP. Her biennial budget request included funding to cover up to 8,500 children by the end of the biennium.

The Governor's 2006 legislative agenda continues these commitments. Her budget included additional funding for CHP, as well as legislation to rule out premiums for children in Medical Assistance programs in families up to 200% of poverty. The Legislature supported these initiatives by enacting the Governor's request to eliminate premium requirements for children below 200% of poverty and added additional CHP funding to cover 11,000 (Senate budget) to 14,000 (House) more children during SFY 2007.

The challenge to achieve coverage for children.

By 2010, it is estimated that publicly financed programs will cover more than 100,000 additional Washington children than at the start of SFY 2005. While underlying conditions in employment and employer-sponsored health coverage for dependents may change, it is estimated that Washington's uninsured rate for children could be below 4.0%, which would be the lowest in the nation.

This coverage level will require employers to continue to offer dependent coverage and for the state to finance a major increase in children's coverage. This will require nearly $2 billion in increased funding over the five years between SFY 2005-10. In order to finance this expansion, we need to improve the quality and efficiency of health care in Washington. The collaborative evidence-based purchasing by the Health Care Authority (HCA), Department of Labor & Industries (L&I) and DSHS will be critical in making a more efficient and effective system needed to reduce the growth rate in health expenditures. It will require us to develop better chronic care management for the 5% of our populations that account for 45% of our health care expenditures. It also will require us to create more transparency in our health-care system and adopt better use of health information technology.

The challenge will be all the more difficult for the BHP and our Medicaid and SCHIP coverage for children because of the reliance on Health Services Account (HSA) funding. Over the past several years, growth in HSA revenue has not kept pace with the growth in HSA expenditures associated with expanded coverage. This year, we had to draw upon State General Funds. There will be a greater HSA deficit next biennium that will require other fund sources to sustain our coverage commitments.

The state also needs to purchase outcome-based health coverage for our children through good primary and preventive care. This past year, we began performance-based contracting with our Healthy Options (HO) contractors to improve both immunization rates and frequency of well child screens. DSHS also participates in other programs to improve the quality of health care for children including ABCD-a program to improve access to dental care for children under age 6 and the Children's Preventive Health Care Collaborative which focuses on improving the delivery of pediatric care. To further the states efforts in expanding outcome-based care, the Governor has directed that HCA and our agency to jointly focus on health outcomes by having our HO, BHP and PEBB contractors focus on a common set of prevention strategies for enrolled children and adults.

Meeting these challenges will be an important part of offering health care coverage for all Washington's children on the Governor's timetable.

[HILL ESSAY]

Cost Containment and Quality

By Steve Hill, Administrator, Health Care Authority

In 1999 the Institute of Medicine (IOM) delivered its landmark report, *To Err is Human*, which concluded that at least 44,000 and as many as 98,000 Americans die each year in hospitals due to preventable medical errors. In 2001, it followed up with *Crossing the Quality Chasm*, a report on our health care system that defined a dramatic gap between the "health care that we now have and the health care that we could have." Together, these reports sound an alarm that health care needs a significant overhaul.

In *Crossing the Quality Chasm*, IOM puts forth a vision for the health care system built around six "aims" for improvement. These are built around the core need for health care to be safe, effective, patient centered, timely, efficient, and equitable. They suggest a model for moving toward these goals by involving employers, government, and health insurance plans in creating a performance-sensitive market that causes the medical care system to redesign and improve.

Here in Washington, Governor Gregoire wants the people of our state to have accessible, affordable, and quality health care. However, the state has been spending more and more of its revenue on health care. Annual state spending on health care has increased $1.8 billion since the year 2000, while Medicaid and state employee health care costs have doubled.

In 2000, health care accounted for about 22 percent of state spending. By 2006, it is projected to consume almost 28 percent. This increase in just six years means that in 2006, the state will spend more than $700 million on health care that could have gone to transportation, education, public safety, or other state priorities. State revenue has grown 3 percent per year while health care spending has grown 9 percent per year. These trends have been ruinous to families, jobs, benefits, and the other priorities of government. These trends are not sustainable.

At the same time, we have a growing access problem that is directly correlated to the cost problem. More and more families, individuals, and employers are being priced out of the health care system. Rising costs are the result of quality and efficiency problems. Defects, wasteful treatments, variability, and inefficiencies in delivery and administration are driving the cost trends. A recent study found that patients get clinically appropriate care only about 55 percent of the time. In a national survey, 135 doctors were asked how they would treat a patient's particular condition. They came back with 82 different treatments. The same patient, the same condition, with 82 different remedies. This variability is ineffective, expensive, and dangerous. It is not quality. Up to an estimated 30 percent of our health care is spent on overuse, underuse, or inappropriate use of health care.

As health care costs continue to rise, employers and governments can afford to provide health care to fewer people. And as fewer people can afford health care, more of them are forced to wait until they are sick enough to go to the emergency room, which is the most expensive place to get treatment. And because the uninsured can't afford to pay for that treatment, employers and government eventually absorb those costs in the form of higher

health care costs. The access problem and its solution are inextricably tied to the quality and efficiency issues in health care.

Governor Gregoire has proposed a five-point strategy for health care: The State simply cannot afford to continue to pour money into health care and hope for costs to eventually decrease. Simultaneously, the Governor has also been very clear that we cannot even consider eliminating insurance coverage for Washington residents as a solution to the cost problem. On the contrary, her goal is to see all children in the state covered by 2010 (see article, Page TK).

She has taken a bolder stance and insisted that the state must actively use its purchasing power to influence quality and efficiency improvements in the health care system. As we move toward health care that is safer and less variable, toward health care use based on evidence, we will have more resources available to provide quality care to all of our population.

Governor Gregoire's initiative proposes five key strategies designed to improve quality and efficiency to make health care affordable and accessible. These strategies are outlined below.

1. Emphasize evidence-based health care

The first strategy is to increase the use of evidence-based medicine in state health care procurements. Evidence-based medicine simply means using the medication or procedure proven to be most effective. Simply stated, it is health care that works and is based on proven practice and scientific research. Our goal is to limit state reimbursement to treatments that work and not to pay for ineffective or harmful treatments.

There are already successful examples of programs that incorporate evidence-based principles. One is the state's preferred drug list. A panel of medical and pharmacy experts created the list, using the best available clinical evidence to determine the most effective and safest drugs for specific conditions. Only when drugs are comparable in effectiveness is the least expensive drug chosen to be on the preferred drug list. The state saved $25 million during the program's first year by getting several state agencies to purchase drugs on that list.

We want to expand this evidence-based orientation into other ways of delivering care. This allows the system to eliminate costly, ineffective and dated treatments that are unsafe, do not work, or have been replaced with better treatments (even more expensive treatments, if necessary) to get the quality needed. It means looking at research, not television commercials, to find the right treatment options.

At the Health Care Authority, the state will establish the State Health Technology Assessment Program (SHTAP), which will operate in many ways like the Prescription Drug Program. Health technology means medical devices, procedures, equipment, diagnostic tests, and other health care services. The University of Washington and similar entities will accumulate and evaluate the current scientific evidence about effectiveness. A Health Technology Clinical Advisory Committee (HTCAC), consisting of medical and scientific experts from the community (not state government employees) will then review

this evidence and make recommendations to the agencies as to whether the various technologies should be covered, not covered, or covered only under guidelines to be established by the HTCAC.

Some would argue that this is another way to "ration" care. Indeed, this is intended to prevent the state from spending money on treatments that don't work, don't improve health, or may be harmful. But it is different in two important aspects: Coverage and reimbursement decisions will be based on the best available medical evidence and recommended by community medical experts, and their decisions will be based on effectiveness, not cost.

We expect to select six to eight health technologies in the first year for evidenced-based review. One example of current evidence-based guidelines is the off-label use of Neurontin, for which the Department of Labor and Industries (L&I) and Department of Social and Health Services (DSHS) established a joint guideline on use. Another is bariatric surgery. After reviewing bariatric surgery in the state and finding great variability in mortality rates, DSHS established guidelines on who qualified for the surgery and where it could be done. We have seen no deaths and lower costs since establishing these guidelines.

2. Better manage chronic care

The second initiative has to do with managing the care of our sickest, most expensive beneficiaries. Five percent of the general population generates 50 percent of all health care costs. This "5-50" population changes through time and it includes people with acute situations, such as trauma or cancer, and people with chronic diseases like diabetes and cardiovascular disease who not only require expensive treatments, but who also develop additional, secondary health problems as a result of their primary affliction.

Getting back to evidence-based medicine, we want to be sure state beneficiaries are getting the best, most-effective treatments. An example of leadership in this area is the Department of Health's (DOH) diabetes collaborative which sets uniform guidelines for best practices and most effective treatments.

But there are also tools to help identify people who have the potential for becoming part of that 5 percent. These "predictive modeling" tools can identify people who are on their way to the terrible quality of life and cost implications of diabetes or heart disease, and can these individuals can be approached to start getting the treatment that will help keep them from becoming part of that 5 percent. Instead of just focusing on those already sick, we can begin to work with the potentially sick by developing care strategies that involve healthier lifestyles and education about their health. The use of such care and disease management programs can be affected through the state purchasing process, by requiring contracted providers and health plans to develop and utilize programs that identify and provide early treatment to people at risk of becoming part of that "expensive five percent." We can also take steps directly with state beneficiaries, particularly those in the Medicaid fee-for-service plans and the state employee's self funded plan, the Uniform Medical Plan.

3. Create more transparency in the health care system

When buying a car, there are a number of resources to compare cost, efficiency, reliability, and crash test results. In order to improve the quality and efficiency of the health care system, we need more transparency and information about the quality and efficiency of providers. This will allow us, as patients, to make better choices. But more importantly, it will motivate the care delivery system to work on improving its quality and efficiency.

There are a number of efforts underway to understand and report on quality and efficiency of health care. Several large health plans are demonstrating leadership in this area, while the National Committee on Quality Assurance (NCQA) is reporting on regional and plan performance. A national collaboration, Care Focused Purchasing (CFP), is beginning to collect claims data from health plans that support larger employers, and a Puget Sound collaboration, the Puget Sound Health Alliance (PSHA) is planning to do the same for local employers and health plans.

While the amount of activity is healthy, it is also confusing to providers since they are being asked to report under a number of frameworks. This is to be expected, given where we are on the maturity curve of this effort. We do need to simplify and standardize the process, but we also need to push ahead to make quality and efficiency information available. One sign that we are approaching a tipping point occurred recently when the Institute of Medicine issued the first of three reports on Redesigning Health Insurance Performance Measures, Payment and Performance Improvement. The first report focuses on the selection of measures to support quality improvement and on the creation of a common infrastructure to guide and manage these measures.

The state will work with others, particularly the PSHA, to create more transparency in the health system. We will not add to the confusion and burden on health plans and providers by asking for our own reporting. But we will be strong advocates for getting quality and efficiency information on providers first to providers, then plans, then payers, and then patients. The state will also use its procurement and contracting practices to encourage transparency. Our hope is that the care system will learn and improve from this information and that we can tilt our purchasing to the highest quality and most efficient providers.

4. Make better use of health information technology

The fourth initiative is to improve health information technology. This is the digital age. But 20 years after PCs appeared on everyone’s desk, doctors are still sending hand-written prescriptions to pharmacists. While some fear the potential abuse of electronic medical records, numerous patients who fled New Orleans had to start from scratch with new doctors who couldn’t access their medical records that were lost or destroyed in the basement of their previous physician.

And the problem isn't just in New Orleans. The transfer of information from primary care to specialists is less-than-optimum due to a lack of commonly-accessed data. As a result, tests already conducted by a primary care physician are then ordered by specialists, and the costs go up some more. An estimated 30 percent of all medical testing is unnecessary and occurs simply because of this lack of communication between doctors. Improved sharing of data will improve safety, aid in decision support, and ultimately reduce errors and lower costs.

Again, the amount of activity in this area—in Spokane, in Whatcom County, at Group Health, and at number of multi-specialty clinics is impressive. There is a legislatively mandated advisory board working on this now with a final report due in December 2006, and we are planning for a limited number of grants to providers (small practices or hospitals) to encourage implementation. In addition, Governor Gregoire will work with the Legislature to create a statewide goal for health information technology. This is another area in which Washington State should be a leader.

5. Promote prevention, healthy lifestyles, and healthy choices

The final initiative concerns prevention. Our health is greatly influenced by genetics, environment, lifestyle, and medical care. The way we live—fitness, smoking, and substance abuse—has a 51 percent influence in our health. Medical care has a 10 percent influence, yet our spending is 95 percent for medical care and less than 3 percent to increase healthy behavior and mitigate health risk factors.

A July 2005 report by the University of Washington Health Promotion Research Center on employment-based prevention programs made the following observation on the need for health promotion programs: "Our research found that chronic diseases, including heart disease, stroke, cancer, lung disease, and diabetes, are among the leading causes of death and disability in the state … yet employed Washingtonians have high levels of risk behaviors that contribute to chronic disease:

- 20 percent smoke
- 44 percent do not meet guidelines for vigorous exercise
- 60 percent are overweight or obese
- Less than half receive age-appropriate colorectal cancer screening.

We need a renewed focus on prevention and wellness, both to improve people's health and to help control the cost of health care. The state, through the Department of Health, has made remarkable progress on some of these areas. Since it started in 2000, the Tobacco Prevention and Control Program has successfully reduced the number of Washington kids smoking by about 65,000 … and the number of adults smoking by 130,000. State government will continue broad, population-based programs, curtail teen smoking, encourage vaccinations, and promote health education.

We will also begin a program with state employees to encourage healthy behaviors. Employees will have access to an online health risk appraisal, where they can confidentially fill out information about their lifestyles, habits, and health history, then

receive information about how to take responsibility for and improve their health. We will follow the models of other public and private employers to establish a “best practice” employment-based wellness program.

In total, these strategies will make Washington state government a national leader in the way we buy and use health care. It will reform the state system so it provides high-quality care at lower cost, while at the same time saving money needed to provide more health care. It also can significantly influence the way private sector health care systems operate in our marketplace.

[WEEKS SIDEBAR TO HILL ESSAY]

Improving Health Care to Reduce Disability

Gary Weeks, Director,
Department of Labor & Industries

A principle goal of the Department of Labor and Industries (L&I) is to have one of the best workers compensation programs in the country. This is crucial to maintaining a healthy workforce and a favorable business climate. Premiums must be affordable and they must ensure workers appropriately have access to benefits that help them recover.

Preventing injuries in the first place is the best way to accomplish that, and over the past decade, employers and workers have made workplaces safer, resulting in a decline in the number of workplace injuries. When injuries do occur, however, workers need access to high quality, effective treatment so they can recover and return to their jobs as soon as they are medically able to do so. This maintains productivity, preserves the worker's relationship with his or her employer and benefits the worker's career over the long term.

L&I has routinely relied on research to help improve the workers' compensation system in ways that reduce the human costs and financial impacts of workplace injuries. Over the past decade, we have significantly improved outcomes for workers and lowered costs. Between 1996 and 2003, our medical costs grew at an average of 6.5 percent annually, while the national average for workers' compensation systems increased an average of 9.3 percent annually. In the past couple years, our medical costs have grown less than 6 percent annually. We have also improved outcomes by using evidence-based medicine. A recent example of this can be found is our two prototype Centers of Occupational Health and Education (COHE).

The idea for the Centers grew out of L&I-funded research at the University of Washington and L&I's belief that workers recover more quickly when they have access to attending doctors who understand occupational health best practices. Studies show that attending doctors who employ such best practices are better able to manage workplace disability and find ways to aid injured workers with their recovery. Our COHEs provide comprehensive support services, training in best practices, and incentives to attending doctors who are willing to use occupational health best practices in care of injured workers.

In June 2002, L&I launched its first COHE at Valley Medical Center in Renton. This is an innovative partnership with a large medical center that has more than decade of experience in occupational health care. In June 2003, we opened our second center at St. Luke's Rehabilitation Institute in Spokane. St. Luke's has extensive experience and skill in injury recovery and the use of information technology to share clinical information with providers.

The COHEs are a unique way to increase occupational health care expertise in their communities. Led by occupational health experts who specialize in treatment of workplace illness and injury, they are centralized community resources for health care providers, employers, workers and labor unions to learn more about return to work and occupational health best practices. This includes increasing awareness about the benefits

of rapidly reporting injuries, setting appropriate patient expectations for return to work, and talking with the employer about workplace accommodations that will help the worker transition back to their job quickly.

L&I encourages doctors to participate by offering higher payments linked to quality measures, free medical education and supportive health services coordinators. Health services coordinators use new technology developed for the COHEs to track high-risk cases and help remove barriers that keep people from returning to work. They also coordinate services for high-risk workers who need more help with their recovery. At the Spokane COHE, providers, employers, workers and unions have access to an online "dashboard" that lets them know when a patient needs a service or has hit a barrier to recovery.

The Department designed the Centers in collaboration with business, labor and providers, with advice from the University of Washington. One goal was to engage physicians in continuous improvement of health care for workers. Few doctors have training in disability prevention and management because it is not clinical in nature and not typically part of their training.

The COHEs are very popular. More than 450 doctors participate and more are interested in joining. Based on the program's popularity, the 2005 Legislature funded an expansion of the Spokane COHE to include 260 more doctors in Central and Eastern Washington. This expansion will provide service 13 additional counties beyond the three that began in 2003.

A recent evaluation by the University of Washington showed that many doctors at Renton COHE were able to substantially reduce disability and get more patients back to work faster. At the same time, workers were highly satisfied with their health care. The 10,000 injured workers treated by participating doctors were 17 percent less likely to miss work due to an on-the-job injury. They also were 65 percent more likely to be working six months after their injury. More importantly, workers treated by participating doctors were 23 percent less likely to be off work at one year. These outcomes are critical in workers' compensation, since research shows that workers who are off work 6 months or more due to disability have only a small chance of ever returning to employment. After 12 months off work the chances of returning to work drop to less than 5 percent.

Provider satisfaction also increased. Doctors reported their ability to treat workplace injuries had improved. There was good financial news, too. Average costs per workers' compensation case were $585 lower for workers who had COHE doctors compared to a group who saw non-COHE providers. Costs for the 10,000 workers were $5.8 million less than a comparison group.

The COHEs also have fostered greater community involvement in health care improvement for injured workers. Both centers have local advisory committees that comprise leaders from business, labor and providers. Collaboration among these partners helps identify and support health care improvements.

Other improvements also are occurring through the COHEs. Feedback from the provider quality improvement committees has helped L&I identify ways to reduce administrative burden and make better use of information technology.

This summer, L&I and its business and labor advisory committee on health care will review the results from the Spokane COHE. We will learn whether the improvements like those that showed promise in the suburban, manufacturing environment in Renton were similarly effective in rural parts of Eastern Washington. More importantly, as we gain experience with the COHEs, not only can we make further refinements and improvements, we gain crucial knowledge for improving the system statewide.

[INSERT CONCLUSION IN JUNE AFTER PUBLIC FORUMS]

Conclusion